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Lee A. Norman, M.D., Secretary

Laura Kelly, Governor

Drug Utilization Review Board
Meeting Agenda, Open Session
July 10, 2019 10:00 a.m. – 2:00 p.m.

Meeting Location
DXC Technology, Building #283, Capital Room
6511 SE Forbes Ave, Topeka, KS 66619

Board Members

Moneeshindra Mittal, MD
James Backes, PharmD
Jennifer Clair, MD
Katie Burenheide Foster, PharmD, MS, BCPS, FCCM
Roger Unruh, DO
LaTonyua Rice, PharmD, CGP
Serena Stutzman, APRN
Arthur Snow, MD

KDHE-DHCF Staff/Contractor

Annette Grant, RPh
Victor Nguyen, PharmD
Markie O'Donnell, Transcriptionist

DXC Technology/KEPRO Staff

Karen Kluczykowski, RPh
Kathy Kaesewurm, RN, BSN
Ariane Casey, PharmD

MCO Staff

Alan Carter, PharmD, **Aetna Better Health of Kansas**
Angie Zhou, PharmD, **Sunflower State Health Plan**
Jeanne Cavanaugh, PharmD, **UnitedHealthcare Community Plan**

I. CALL TO ORDER

A. Announcements and Introductions

II. OLD BUSINESS

A. Review and Approval of April 10, 2019 Meeting Minutes

III. NEW BUSINESS

A. New Preferred Drug List (PDL) Class

1. **IMMUNOMODULATION AGENTS – ASTHMA**
   At the June 2019 PDL meeting, the committee approved the addition of asthma immunomodulators to the PDL. Standard non-preferred prior authorization criteria are being proposed for this new class to allow access to non-preferred agents.
   i. Non-Preferred PDL PA Criteria
   ii. *Public Comment
   iii. Board Discussion

B. Revised Prior Authorization (PA) Criteria

1. **NON-PREFERRED PDL PA CRITERIA**
   The Non-preferred PDL PA criteria were last updated in April 2019. This is being revised to provide continuity between the PDL program and the Clinical PA program and streamline the PA reviewer process.
   i. Revised PA Criteria
   ii. *Public Comment
   iii. Board Discussion

2. **CGRP RECEPTOR ANTAGONISTS**
   The prior authorization criteria were last revised in January 2019 and is being revised to clarify the criteria for use.

   i. Revised PA Criteria
   ii. *Public Comment
   iii. Board Discussion

3. **BOTULINUM TOXINS**
   The prior authorization criteria were last revised in January 2019 and is being revised to clarify the criteria for use.

   i. Revised PA Criteria
   ii. *Public Comment
   iii. Board Discussion

4. **TOPIRAMATE EXTENDED RELEASE**
   The prior authorization criteria were last revised in April 2019 and is being revised to clarify the criteria for use.

   i. Revised PA Criteria
   ii. *Public Comment
   iii. Board Discussion

5. **BLANKET STATEMENT – NEW INDICATIONS/AGE CHANGES**
   This revision modifies all prior authorization criteria to include a statement regarding new and/or non-listed indications or age for use changes. This revision expands coverage for indications or age that are not addressed in current prior authorization criteria**.** In addition, the Provider Group identifier would change to Billing Code Type. No other changes will be made.

   i. Revised PA Criteria
   ii. *Public Comment
   iii. Board Discussion

C. New Prior Authorization (PA) Criteria

1. **ADULT RHEUMATOID ARTHRITIS**
   These criteria will combine and supersede all previous criteria for agents used for the treatment of adult rheumatoid arthritis. The prior authorization criteria are being proposed to ensure appropriate use based upon the FDA-approved labeling information and be consistent with similar agents.
   i. Prior Authorization Criteria
   ii. *Public Comment
   iii. Board Discussion

2. **ANKYLOSING SPONDYLITIS**
   These criteria will combine and supersede all previous criteria for agents used for the treatment of ankylosing spondylitis. The prior authorization criteria are being proposed to ensure appropriate use based upon the FDA-approved labeling information and be consistent with similar agents.
   i. Prior Authorization Criteria
   ii. *Public Comment
   iii. Board Discussion

3. **ASTHMA**
   These criteria will combine and supersede all previous criteria for agents used for the treatment of asthma. The prior authorization criteria are being proposed to ensure appropriate use based upon the FDA-approved labeling information and be consistent with similar agents.
   i. Prior Authorization Criteria
   ii. *Public Comment
   iii. Board Discussion

4. **ATOPIC DERMATITIS**
   These criteria will combine and supersede all previous criteria for agents used for the treatment of atopic dermatitis. The prior authorization criteria are being proposed to ensure appropriate use based upon the FDA-approved labeling information and be consistent with similar agents.
   i. Prior Authorization Criteria
   ii. *Public Comment
   iii. Board Discussion

5. **CROHN'S DISEASE**
   These criteria will combine and supersede all previous criteria for agents used for the treatment of Crohn's disease. The prior authorization criteria are being proposed to ensure appropriate use based upon the FDA-approved labeling information and be consistent with similar agents.
   i. *Public Comment
   ii. Board Discussion

6. **JUVENILE IDIOPATHIC ARTHRITIS**
   These criteria will combine and supersede all previous criteria for agents used for the treatment of juvenile idiopathic arthritis. The prior authorization criteria are being proposed to ensure appropriate use based upon the FDA-approved labeling information and be consistent with similar agents.
   i. *Public Comment
   ii. Board Discussion

7. **PLAQUE PSORIASIS**
   These criteria will combine and supersede all previous criteria for agents used for the treatment of plaque psoriasis. The prior authorization criteria are being proposed to ensure appropriate use based upon the FDA-approved labeling information and be consistent with similar agents.
   i. *Public Comment
   ii. Board Discussion

8. **PSORIATIC ARTHRITIS**
   These criteria will combine and supersede all previous criteria for agents used for the treatment of psoriatic arthritis. The prior authorization criteria are being proposed to ensure appropriate use based upon the FDA-approved labeling information and be consistent with similar agents.
   i. *Public Comment
   ii. Board Discussion

9. **ULCERATIVE COLITIS**
   These criteria will combine and supersede all previous criteria for agents used for the treatment of ulcerative colitis. The prior authorization criteria are being proposed to ensure appropriate use based upon the FDA-approved labeling information and be consistent with similar agents.
   i. *Public Comment
   ii. Board Discussion

10. **SPINAL MUSCULAR ATROPHY**
    These criteria will combine and supersede all previous criteria for agents used for the treatment of spinal muscular atrophy. The prior authorization criteria are being proposed to ensure appropriate use based upon the FDA-approved labeling information and be consistent with similar agents.
    i. *Public Comment
    ii. Board Discussion

D. **Mental Health Medication Advisory Committee (MHMAC)**

1. ANTIDEPRESSANTS – SAFE USE FOR ALL AGES
At the May 2019 MHMAC meeting, the committee revised the criteria for use of Antidepressants – Safe Use for All Ages prior authorization (PA), to include Spravato®. The criteria were last reviewed in October 2018.
   i. Prior Authorization Criteria
   ii. *Public Comment
   iii. Board Discussion

E. **Miscellaneous Items**

1. **Managed Care Organization Annual Reports**
   Aetna Better Health of Kansas, Sunflower State Health Plan, and UnitedHealthcare Community Plan will present reports detailing utilization trends and provider education efforts for 2018.
   i. Aetna Individual Report – Alan Carter, PharmD
   ii. Sunflower Individual Report – Angie Zhou, PharmD
   iii. UnitedHealthcare Individual Report – Jeanne Cavanaugh, PharmD
   iv. *Public Comment
   v. Board Discussion

IV. APPOINTMENT OF CHAIRPERSON AND INTERIM CHAIRPERSON

V. OPEN PUBLIC COMMENT

VI. ADJOURN

Lunch will be provided for the DUR Board members.
The next DUR Board meeting is scheduled for October 09, 2019.